

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

00861

Reg. Dist. No. 2690

## SOMERSET CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19 87 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Jan 1 19 87

Immediate cause of death: Myocarditis

DURATION

Arteriosclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address.....

Date signed 1/2-87

Male White Married  
 6. (b) Name of husband or wife: Mary Bennett  
 7. Birth date of deceased (mo., day, yr.): 1874  
 8. AGE: 82 Years 13 Months 13 Days If less than one day hrs. min.

9. Birthplace: Orisles, Md.  
 10. Usual occupation: Carpenter  
 11. Industry or business: Wood Working

12. Name: John Bennett  
 13. Birthplace: Orisles, Md.  
 14. Maiden name: Sarah Johnson  
 15. Birthplace: Orisles, Md.

16. Informant: Mrs. Thos Bennett  
 Address: Orisles, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof: Jan 4-87 (month) (day) (year)

Cemetery or crematory: Mount Carmel Cemetery  
 Location: Orisles, Md.

18. Funeral director: H. H. H. H. H.  
 Address: Desl. Island

19. Jan 4 19 87 Date rec'd by registrar

Registrar: J. S. Bennett

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JAN 8 1947

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PAC CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01038

Reg. Dist. No.

2700

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield Hospital  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred: Mc Coady Memorial Hospital.  
 How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Somerset  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Theodore Briscoe

## 3. (b) Social Security Number

212-12-5485

## 4. Sex

M.

## 5. Color or race

Col.

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Anna Briscoe

## 7. Birth date of

deceased (mo., day, yr.)

March 13, 1879

## 8. AGE:

Years

Months

Days

If less than one day

67109

hrs.

min.

## 9. Birthplace

Saint Marys County, Md.  
(Town, county, and state)

## 10. Usual occupation

Seafarer

## 11. Industry or business

FATHER

## 12. Name

Abraham Briscoe

## 13. Birthplace

Saint Marys County

MOTHER

## 14. Maiden name

Laura Hukusawa

## 15. Birthplace

Saint Marys County, Md.

## 16. Informant

Ruby Barton

## Address

Crisfield Md. 1065. 4th St.

## 17. (Burial, cremation, or removal. Which?)

Burial

## Date thereof

Feb 2, 1947

## Cemetery or crematory

Presley

## Location

Marion Sta., Md.

## 18. Funeral director

Charles H. Stark

## Address

Marion Sta., Md.

## 19. (Date rec'd by registrar)

1/30/47Agatha E. Frazier  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 29th 19 47 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 20 19 47 to Jan 29 19 47and that I last saw him alive on Jan 28 19 47

Immediate cause of death

Acute Deep Heart

DURATION

Due to

Chronic Int. valvular2 yrs

Due to

Chronic myocardial

Other conditions

John C. Cullen6 days

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

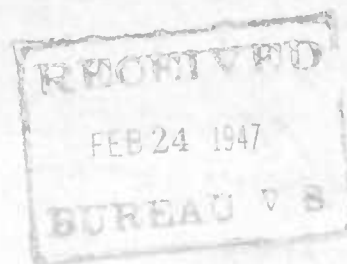
23. SIGNATURE

James E. Cullen

M. D. or other

Address

Marion Sta. Md.Date signed 1-30-47



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

00862

Reg. Dist. No.

2610

## 1. PLACE OF DEATH:

County..... Somerset  
 City or town..... Rural, Marion, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Lifetime  
 Hospital, institution, or street address where death occurred:  
 Rural, Marion, Md.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Somerset  
 City or town..... Rural, Marion, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Rural, Cash Corner  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Clifton H. Butler

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... Anna Harrison  
 7. Birth date of deceased (mo., day, yr.)..... November 28, 1897  
 6. (c) If alive, give age..... 40 years  
 8. AGE: Years..... 49 Months..... 1 Days..... 22 It less than one day..... hrs. .... min.

Marion-Somerset-Maryland  
 9. Birthplace..... (Town, county, and state)  
 10. Usual occupation..... Farmer  
 11. Industry or business..... Agriculture  
 FATHER 12. Name..... Gordon T. Butler  
 13. Birthplace..... Somerset County, Md.  
 MOTHER 14. Maiden name..... Ella Parker  
 15. Birthplace..... Cash Corner, Md.  
 16. Informant..... Clarence Butler  
 Address..... Crisfield, Md.  
 17. (Burial, cremation, or removal. Which?)..... Burial Date thereof..... Jan 22, 1947  
 (month) (day) (year)  
 Cemetery or crematory..... St. Pauls Cemetery  
 Location..... Rural, Marion, Md.  
 18. Funeral director..... H. Harvey Bradshaw  
 Address..... Crisfield, Md.  
 19. (Date rec'd by registrar)..... 2/27 1947 Registrar..... G. J. Wilson

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 20 1947 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to Jan 1947 and that I last saw him alive on Jan 1947.

Immediate cause of death..... Acute Dil. of Heart  
 DURATION..... 1 week

Due to..... Chronic myocarditis

Due to..... Chronic myocarditis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed..... 1/22/47

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 a

00863

## CERTIFICATE OF DEATH

Reg. Dist. No.

2610

### 1. PLACE OF DEATH:

County Somerset  
City or town Marion  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 62  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Somerset  
City or town Marion  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Samuel J. Bottman

### 3. (b) Social Security Number

212-16-1393

4. Sex Male 5. Color or race Cal 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Minnie Bottman  
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26-1885

8. AGE: Years 62 Months 6 Days 6 If less than one day hrs. min.

9. Birthplace Marion Somerset Co MD  
(Town, county, and state)

10. Usual occupation seafood work

11. Industry or business

12. Name Jeffer Bottman

13. Birthplace Somerset Co MD

14. Maiden name Sallie Anne Jones

15. Birthplace Somerset Co MD

16. Informant Titus Bottman

Address Marion Sta. MD

17. burial Date thereof Jan 5 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory weebay cemetery

Location Marion MD

18. Funeral director Chas H Ward

Address Marion MD

19. Jan 4 1947 Chas J Wilson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1947 at 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Jan 1 1947

and that I last saw him alive on Dec 31 1946

Immediate cause of death Ague Dec 2 Heart

Due to Chloroform

Due to Chloroform

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas J Wilson M. D. or other

Address Marion MD Date signed Jan 3-47

MARGIN RESERVED FOR BINDING

9-43-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

## CERTIFICATE OF DEATH

Reg. Dist. No. 2701

## 1. PLACE OF DEATH:

County..... **Somerset**  
 City or town..... **Crisfield**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **5 days**  
 Hospital, institution, or street address where death occurred:  
**McCready Memorial Hospital**  
 How long in hospital or institution?..... **5 days**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... **Maryland** County..... **Somerset**  
 City or town..... **Crisfield**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... **RURAL**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**George Dewey Cox, Jr.**

## 3. (b) Social Security Number

**220-12-1298**

4. Sex..... **Male** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Married**  
 6. (b) Name of husband or wife..... **Edith Duncan**  
 6. (c) If alive, give age..... **20** years  
 7. Birth date of deceased (mo., day, yr.)..... **February 21, 1925**  
 8. AGE: Years..... **21** Months..... **10** Days..... **9** If less than one day..... hrs. .... min.

8. Birthplace..... **Laurel-Sussex-Delaware**  
 (Town, county, and state)  
 10. Usual occupation..... **Farmer**  
 11. Industry or business..... **Truck farming**  
 12. Name..... **Geo. Dewey Cox, Sr.**  
 13. Birthplace..... **Crisfield, Maryland**  
 14. Maiden name..... **Sarah Hickman**  
 15. Birthplace..... **Kingston, Maryland**

16. Informant..... **Geo. Dewey Cox**  
 Address..... **Crisfield, Maryland**  
 17. Burial Date thereof..... **Jan. 13, 1947**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... **Private Cemetery**  
 Location..... **RURAL, Crisfield, Md.**

18. Funeral director..... **H. Harvey Bradshaw**  
 Address..... **Crisfield, Maryland**

19. (Date rec'd by registrar)..... **Jan 23 1947** Registrar.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Jan 10 1947** at **4 A** M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Dec 24 1946** to **Jan 10 1947**  
 and that I last saw him alive on **Jan 09 1946**

Immediate cause of death..... **Acute Deep Heart**  
 DURATION.....

Due to..... **Arteriosclerosis** 14 days

Due to..... **Infarction**

Other conditions..... **Myocarditis** 2 years  
**Pneumonia**

(Include pregnancy within 3 months of death)  
 Major findings of operations..... **none**

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... **Gray C. Claiborne - M.D.**  
 Address..... **Law 15, 47** Date signed.....

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FEB 24 1947  
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MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00864

131a

Reg. Dist. No. 2610

### 1. PLACE OF DEATH:

County Somerset  
 City or town Marion  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 66 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Ind County Somerset  
 City or town Marion  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Frank James Brownell

### 3. (b) Social Security Number

214-08-7547

4. Sex Male 5. Color or race Cal 6. (a) Single, married, widowed, or divorced Widower  
 6. (b) Name of husband or wife Mary R Brownell  
 7. Birth date of deceased (mo., day, yr.) Mar 10 1880  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 66 Months 10 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1947 at 6 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 11 1947 and that I last saw him alive on Jan 5 1947  
 Immediate cause of death Acute Dist Nephritis DURATION 2 yrs  
 Due to Chronic Dist Nephritis  
 Due to Chronic Nephritis  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

9. Birthplace Accomack Co Va  
 (Town, county, and state)  
 10. Usual occupation seafar worker  
 11. Industry or business \_\_\_\_\_  
 12. Name Frank Brownell  
 13. Birthplace Accomack Co Va  
 14. Maiden name Emma J Hall  
 15. Birthplace Accomack Co Va  
 16. Informant Gilbert L Brownell  
 Address Marion & to, Md.

17. Burial Date thereof Jan 14-1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Wesley Cemetery  
 Location Marion Md  
 18. Funeral director Chas H Ward  
 Address Marion Md.  
 19. Jan 14 1947 \_\_\_\_\_  
 (Date rec'd by registrar) Registrar

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE James A. Cullen M.D. M. D. or other  
 Address Marion & to, Md. Date signed Jan 15-47

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JAN 16 1947  
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MARGIN RESERVED FOR BINDING

VS A15-9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 00865  
 Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County... SOMERSETCity or town... PRINCESS ANNE  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

WASHINGTON HOTELHow long in hospital or institution? 1 DAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD. County... BALT.City or town... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3611 FOREST PARK AVE.  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Samuel Debois

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Rose Debois

7. Birth date of deceased (mo., day, yr.)

18908. AGE: Years 57 Months Days If less than one day hrs. min.9. Birthplace BALTIMORE, MD.  
(Town, county, and state)10. Usual occupation MERCHANT

11. Industry or business

12. Name UNK13. Birthplace UNK14. Maiden name UNK15. Birthplace UNK16. Informant JACK LEWIS, INC.Address 2100 EUTAW PLACE17. BURIAL Date thereof 1-24-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BALTIMORE NEWBORNLocation BELAIR ROAD18. Funeral director W. G. MarshallAddress Princess Anne, Md.19. Jan 23 19 47 R. W. Yedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1947 at 4:30 A.

21. I CERTIFY that death occurred on the date above stated that I attended deceased from

and that I feel saw him alive on

Immediate cause of death Heart Disease

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

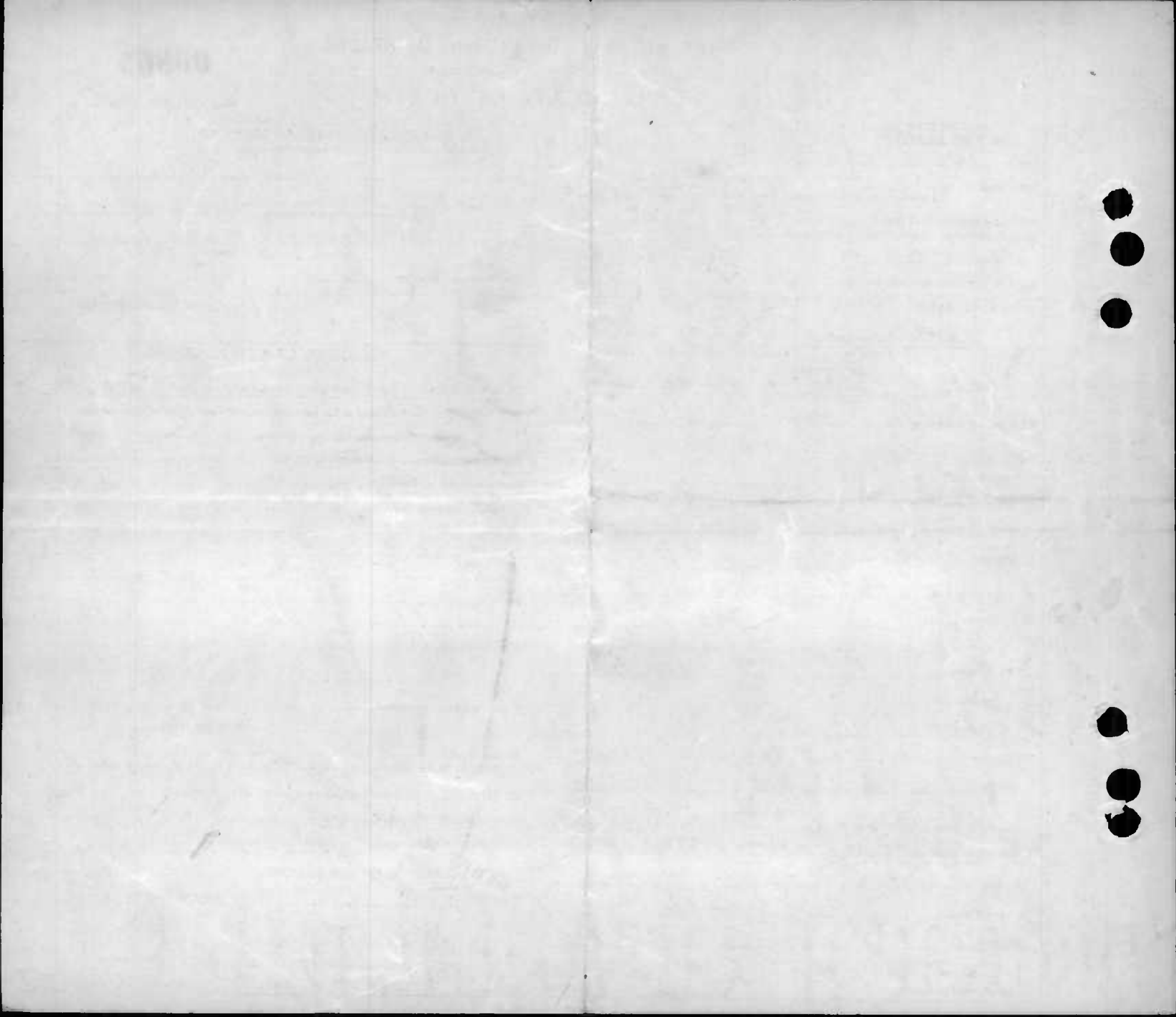
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Henry M. Paulford MD M. D. or otherAddress Princess Anne, Md. Date signed 1/22/47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

## CERTIFICATE OF DEATH

Reg. Dist. No.

01042

2700

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:  
McCreedy Memorial Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 113 Second Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

MAE VIOLA ELLIOTT

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Milbourne Elliott  
 6.(c) If alive, give age 67 years  
 7. Birth date of deceased (mo., day, yr.) May 23, 1900

8. AGE: Years 46 Months 8 Days 4 It less than one day  
 .... hrs. .... min.

9. Birthplace Hallwood-Accomac-Virginia  
 (Town, county, and state)  
 10. Usual occupation Seafood Worker

11. Industry or business Seafood

FATHER 12. Name William King  
 13. Birthplace Ireland

MOTHER 14. Maiden name Jane Hitchens  
 15. Birthplace Millsboro, Delaware

16. Informant Mrs. Dorothy Hancock  
 Address 2nd St., Crisfield, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Jan 30, 1947  
 (month) (day) (year)

Cemetery or crematory Crisfield Cemetery  
 Location Chesapeake Ave., Crisfield

18. Funeral director H. Harvey Bradshaw  
 Address Crisfield, Maryland

19. 1/30/47 Registrar Agatha E. Franklin  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1947 at 9:20 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 25, 1947 to Jan. 27, 1947  
 and that I last saw her alive on Jan. 27, 1947

Immediate cause of death Carcinoma of bladder

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Sarah M. Peyton M.D.  
 M. D. or other  
 Address Crisfield Md Date signed Jan 30 1947



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FEB 24 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1310

00866

Reg. Dist. No. 2610

### 1. PLACE OF DEATH:

County Somerset  
City or town Marion  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life time  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Somerset  
City or town Marion Sta., Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Lucy Evans

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife George Evans  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) March 17, 1878

8. AGE: Years 68 Months 10 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Marion, Somerset, Md.  
(Town, county, and state)

10. Usual occupation Domestic Work

### 11. Industry or business

FATHER 12. Name Alexander Whittington  
13. Birthplace Marion Sta., Md.

MOTHER 14. Maiden name Candice Horsey  
15. Birthplace Marion Sta., Md.

16. Informant Paul Evans  
Address Marion Sta., Md.

17. Burial Burial Date thereof Jan. 28, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wesley  
Location Marion Sta., Md.

18. Funeral director Charles A. Ward  
Address Marion Sta., Md.

19. Jan 27 47 Geo J Nelson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 19 47 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17 19 47 to Jan 24 19 47  
and that I last saw her alive on Jan 24 19 47

Immediate cause of death Acute Dec of Heart DURATION 10 days  
united

Due to Chronic Lung Disease 2 yrs

Due to Chronic myocarditis 2 yrs

Other conditions Paul's other diseases

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George J Nelson M. D. or other \_\_\_\_\_  
Address Marion Sta Md Date signed Jan 23 47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 29 1947

BUCHHEAL T S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00867

Reg. Dist. No. 2680

## 1. PLACE OF DEATH:

County... Somerset  
City or town... Deal Island Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... lifetime  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Algier Harris

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Black

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Lucy Harris

## 7. Birth date of deceased (mo., day, yr.)

Not Obtainable

## 6. (c) If alive, give age years

## 8. AGE:

Years 79 Months Days If less than one day hrs. min.

## 9. Birthplace

Deal Island Md  
(Town, County, and state)

## 10. Usual occupation

Oysterman

## 11. Industry or business

Henry Harris

## 12. Name

Deal Island

## 13. Birthplace

Adeline Milbourne

## 14. Maiden name

Deal Island Md

## 15. Birthplace

Lucy Harris

## 16. Informant

Deal Island Md

## Address

Burial

## 17. (Burial, cremation, or removal. Which?)

Date thereof Jan 22 - 47

## Cemetery or crematory

Deal Island Md

## Location

H. H. H. H.

## 18. Funeral director

Deal Island Md

## Address

Jan 22 1947 Rosa Wetzel Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Somerset

City or town... Deal Island  
(If outside city or town limits, write RURAL and give nearest town)

Street No.  
(If rural, give LOCATION)

2. (d) If veteran, name war

## MEDICAL CERTIFICATION 47

20. DATE OF DEATH Jan 20th 1947 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1941 to Jan 17 1947 and that I last saw him alive on Jan 17 1947

Immediate cause of death... Coronary Thrombosis

Due to... Arteriosclerosis

Due to...

Other conditions... Myocardium

(Include pregnancy within 3 months of death)

Major findings of operations...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Mathis M.D. or other

Address... Princess Anne Date signed 1/22/47

## DURATION

4 days

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JAN 30 1947

BUREAU

2-35

*Permanently*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

## CERTIFICATE OF DEATH

Reg. Dist. No. 00868 2610

## 1. PLACE OF DEATH:

County SomersetCity or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. Columbia Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Louis Morris Layfield

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Lyda Layfield7. Birth date of deceased (mo., day, yr.) January 8, 1872 8.(c) If alive, age 69 years8. AGE: Years 76 Months — Days — If less than one day — hrs. — min.9. Birthplace Westover, Somerset, Md  
(Town, county, and state)10. Usual occupation Farming

## 11. Industry or business

12. Name Peter Layfield13. Birthplace Westover, Md.14. Maiden name Unknown15. Birthplace Peter Layfield16. Informant Princess Anne, Md.Address Princess Anne, Md.17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof January 14, 1947  
(month) (day) (year)Cemetery or crematory St Andrews CemeteryLocation Princess Anne, Md.18. Funeral director Dale WashellAddress Princess Anne, Md.19. Jan 9 1947 Anna J. Wilson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1947 at 4:50 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27, 1946 to Jan 8, 1947and that I last saw him alive on January 8, 1947Immediate cause of death Acute BasilarStenosisDue to Chronic MyocarditisCerebral HemorrhageDue to General Arterio Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Houlton, M.D.Address Crisfield Md Date signed Jan 8, 1947

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

STATE OF CALIFORNIA

DEATH

RECEIVED

JAN 10 1947

BUREAU

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 465

## CERTIFICATE OF DEATH

Reg. Dist. No. 01040  
2650

## 1. PLACE OF DEATH:

County..... Somerset  
City or town..... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 17 years  
Hospital, institution, or street address where death occurred:  
117 N. 4th St.  
How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Somerset  
City or town..... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 117 N. 4th St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

## 3. (a) FULL NAME

MARION MILBOURNE

## 3. (b) Social Security Number

4. Sex..... M 5. Color or race..... C 6. (a) Single, married, widowed, or divorced..... Married

8. (b) Name of husband or wife..... Annie Miles

7. Birth date of deceased (mo., day, yr.)..... August 1, 1897  
6. (c) If alive, give age..... years

8. AGE: Years..... 49 Months..... 5 Days..... 15 If less than one day..... hrs. .... min.

9. Birthplace..... Marumsco-Somerset-Md  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... Poultry Feed

12. Name..... William Milbourne

13. Birthplace..... Marumsco, Md.

14. Maiden name..... Sally Stokeley

15. Birthplace..... Marumsco, Md.

16. Informant..... William Stokeley

Address..... 139 1/2 S. 4th St-Crisfield

17. (Burial, cremation, or removal. Which?)..... Burial Date thereof..... Jan. 19, 1947  
(month) (day) (year)

Cemetery or crematory..... Marumsco Cemetery

Location..... RURAL, Marion, Maryland

18. Funeral director..... H. Harvey Bradshaw

Address..... Crisfield, Md.

19. 1/18/47 19. Agatha E. Franklin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 16, 1947, at 9:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 14, 1947, to Jan. 16, 1947, and that I last saw him alive on Jan. 16, 1947.

Immediate cause of death..... Consumption of stomach  
DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

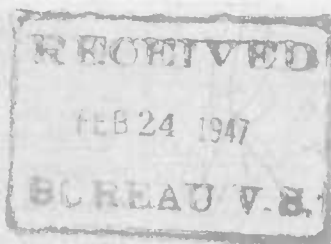
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Samuel M. Peyton M.D.

Address..... Crisfield, Md. Date signed..... Jan. 18, 1947



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2600

1. PLACE OF DEATH: Somerset  
County  
City or town: Upper Fairmount  
How long in above place of death? all of life  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State: County:  
City or town: (If outside city or town limits, write RURAL and give nearest town)  
Street No.: (If rural, give LOCATION)  
2.(a) If veteran, name war:

3. (a) FULL NAME Sally E. Miles

3. (b) Social Security Number

4. Sex: Female  
5. Color or race: White  
6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): Oct. 4, 1844  
6. (c) If alive, give age: years

8. AGE: Years: 102 Months: 3 Days: 17  
If less than one day: hrs. min.

9. Birthplace: Maryland  
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

12. Name: Tom Hall  
13. Birthplace: Md.

14. Maiden name: Mary Anne Maddox  
15. Birthplace: Md.

16. Informant: Genolia Miles  
Address: Upper Fairmount Md

17. Burial, cremation, or removal (Which?): Burial  
Date thereof: Feb. 3, 1947  
(month) (day) (year)

Cemetery or crematory: Private Family lot  
Location: Upper Fairmount Md

18. Funeral director: Harry B. Miles  
Address: Upper Fairmount, Md

19. Date rec'd by registrar: Feb. 6, 1947  
Registrar: R. D. Johnson M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2, 1947 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20<sup>th</sup> 1947 to Jan. 23<sup>rd</sup> 1947  
and that I last saw him alive on Jan. 20 1947

Immediate cause of death: Myocardial Failure  
DURATION: 2 d.

Due to: generalized arteriosclerosis

Due to: Hypertension

Other conditions: Debelled's Gungu 1 mo.

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE: R. B. Wheeler  
M. D. or other

Address: Queen Anne's Date signed: 2/6/47

RETURN TO THE BUREAU OF INVESTIGATION

STATE OF TEXAS

DEPARTMENT OF HEALTH

REGISTERED MEDICAL

RECEIVED  
FEB 10 1947  
BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

## CERTIFICATE OF DEATH

Reg. Dist. No. 00870 2600

## 1. PLACE OF DEATH:

County SouthernCity or town Pocomoke Md. RFD  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

John Roberts

## 3. (b) Social Security Number

4. Sex male5. Color or race negro6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Jan. 6. 1910

6. (c) If alive, give age..... years

8. AGE: Years 37 Months 12 Days..... hrs. .... min.9. Birthplace North Carolina  
(Town, county, and state)10. Usual occupation labor

11. Industry or business.....

12. Name William Roberts13. Birthplace North Carolina14. Maiden name Rosa Hunter15. Birthplace North Carolina16. Informant William RobertsAddress R.F.D. #1 Box 155 Pocomoke Md17. Burial (Burial, cremation, or removal. Which?) BuriedDate thereof 1-28-47  
(month) (day) (year)Cemetery or crematory Alma HouseLocation Princess Anne Mt. Vernon18. Funeral director William H. James Jr.Address Princess Anne, Md.19. Date rec'd by registrar Jan 28 1947Registrar R. S. Phagan

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1947 at 2 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from.....

..... 19..... 10..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Broken neck

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results Broken neck

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 1/19/47Where did injury occur Pocomoke RFD (City or town) (County) (State)Injured at home, farm, industry, public place (where?) FarmMeans of injury Shot by hunter Injured at work? No23. SIGNATURE Henry M. Sanborn M. D. or otherAddress Baltimore Md Date signed 1/28/47

# MARYLAND STATE DEPARTMENT OF HEALTH

1001 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1. USUAL RESIDENCE (HOME) OF DECEASED  
(For persons having residence in Maryland)

(City)

(State)

2. PLACE OF DEATH (For persons having residence in Maryland)

3. CAUSE OF DEATH (For persons having residence in Maryland)

4. DATE OF DEATH

5. PLACE OF DEATH (For persons having residence in Maryland)

### MEDICAL CERTIFICATION

6. I, the undersigned, being a duly qualified physician, do hereby certify that the death occurred on the date above stated, and I further certify that

7. The death occurred at the place above stated, and I further certify that

8. The death occurred at the place above stated, and I further certify that

9. The death occurred at the place above stated, and I further certify that

10. The death occurred at the place above stated, and I further certify that

11. The death occurred at the place above stated, and I further certify that

12. The death occurred at the place above stated, and I further certify that

13. The death occurred at the place above stated, and I further certify that

14. The death occurred at the place above stated, and I further certify that

15. The death occurred at the place above stated, and I further certify that

16. The death occurred at the place above stated, and I further certify that

17. The death occurred at the place above stated, and I further certify that

18. The death occurred at the place above stated, and I further certify that

19. The death occurred at the place above stated, and I further certify that

20. The death occurred at the place above stated, and I further certify that

21. The death occurred at the place above stated, and I further certify that

22. The death occurred at the place above stated, and I further certify that

23. The death occurred at the place above stated, and I further certify that

24. The death occurred at the place above stated, and I further certify that

25. The death occurred at the place above stated, and I further certify that

26. The death occurred at the place above stated, and I further certify that

27. The death occurred at the place above stated, and I further certify that

28. The death occurred at the place above stated, and I further certify that

29. The death occurred at the place above stated, and I further certify that

30. The death occurred at the place above stated, and I further certify that

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JAN 29 1947

BUREAU

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

## CERTIFICATE OF DEATH

Reg. Dist. No. 2660

<b>1. PLACE OF DEATH:</b> County..... <u>Somerset</u> City or town..... <u>Rhodes Point, Smith I.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>Lifetime</u> Hospital, institution, or street address where death occurred: <u>Home</u> How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Somerset</u> City or town..... <u>Rhodes Point, Smith Island</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war..... <u>No</u>			
<b>3. (a) FULL NAME</b> <u>Alex</u> <b>ALEXANDER MERRILL TYLER</b>				<b>3. (b) Social Security Number</b> <u>U nknown</u>			
<b>4. Sex</b> <u>M</u>		<b>5. Color or race</b> <u>W</u>		<b>6.(a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6.(b) Name of husband or wife</b> <u>Myrtie Evans Tyler</u>						<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> ..... <u>Jan. 20, 1947</u> at <u>10:30</u> AM	
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>January 20, 1889</u>						<b>21. I CERTIFY that death occurred on the date above stated: that I attended deceased from</b> <u>Jan. 20, 1947</u> to <u>Jan. 20, 1947</u> and that I last saw h..... <u>im</u> alive on <u>Jan. 18, 1947</u> <b>Immediate cause of death</b> ..... <u>Coronary Thrombosis</u> <b>DURATION</b> <u>Unknown</u>	
<b>8. AGE:</b> Years <u>58</u> Months <u>0</u> Days <u>0</u> If less than one day ..... hrs. .... min.		<b>6.(c) If alive, give age</b> ..... years					
<b>9. Birthplace</b> ..... <u>Rhodes Point-Somerset-Md.</u> (Town, county, and state)							
<b>10. Usual occupation</b> ..... <u>Waterman</u>							
<b>11. Industry or business</b> ..... <u>Seafood</u>							
<b>MOTHER</b> <b>FATHER</b>	<b>12. Name</b> ..... <u>Severn Tyler</u>						
	<b>13. Birthplace</b> ..... <u>Smith Island</u>						
	<b>14. Maiden name</b> ..... <u>Milkey Dize</u>						
<b>15. Birthplace</b> ..... <u>Smith Island</u>							
<b>16. Informant</b> ..... <u>Vincent Tyler</u> Address..... <u>Rhodes Point, Md.</u>							
<b>17. (Burial, cremation, or removal. Which?)</b> ..... <u>Burial</u> Date thereof..... <u>Jan 23, 1946</u> (month) (day) (year) Cemetery or crematory..... <u>Rhodes Point Meth Cem</u> Location..... <u>Rhodes Point, Md.</u> <b>18. Funeral director</b> ..... <u>H. Harvey Bradshaw</u> Address..... <u>Crisfield, Md.</u>							
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide..... -- Date of -- Where did injury occur?..... -- (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... -- Injured at work? --							
<b>23. SIGNATURE</b> ..... <u>M.G. Chambers M.D.</u> <u>Ewell Md.</u> Address..... Date signed..... <u>Jan 24 1947</u>							

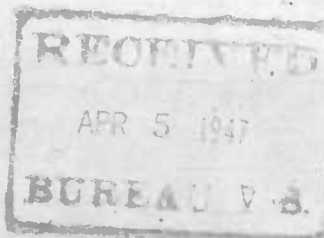
 19. Jan 24 19 47  
 (Date rec'd by registrar)

Registrar

Address

Date signed





2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

## CERTIFICATE OF DEATH

Reg. Dist. No.

01041  
2650

## 1. PLACE OF DEATH:

County... SomersetCity or town... Crofton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

William

7. Birth date of deceased (mo., day, yr.)

Jan 11, 1888

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

5917

hrs.

min.

9. Birthplace

Crofton

(Town, county, and state)

10. Usual occupation

Operator

11. Industry or business

Crofton Md. Sea

FATHER

12. Name

John B. Ruggles

13. Birthplace

Md

MOTHER

14. Maiden name

Rose J. Boyd

15. Birthplace

Md

16. Informant

Housekeeper

Address

Crofton

17.

(Burial, cremation, or removal, Which?)

Date thereof

1/31/47  
(month) (day) (year)

Cemetery or crematory

Crofton

Location

Crofton

18. Funeral director

Harold H. Hunsford

Address

306 Main St. Crofton Md

19.

(Date rec'd by registrar)

19.

Agatha E. Franklin  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Somerset

City or town

Crofton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

R 3 10 B

(If rural, give LOCATION)

2. (a) If veteran, name war

None

## 3. (b) Social Security Number

217-09-6669

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 28

19

47

at

6

P.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 25

19

45

to

Jan 28

19

47

and that I last saw him alive on

January 25

19

47

Immediate cause of death

Heart failure of 24 hours

DURATION

1 day

Due to

Coronary artery disease2 years

Due to

Coronary artery disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Agatha E. Franklin

M. D. or other

Address

306 Main St. Md.

Date signed

Jan 31, 47

RECEIVED

FEB 24 1947

BUREAU V 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2610

## 1. PLACE OF DEATH:

County... SomersetCity or town... Marion  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... all of life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... SomersetCity or town... Marion  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Dorothy Young

## 3. (b) Social Security Number

219-03-47934. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or ~~wife~~ Gordy Young7. Birth date of deceased (mo., day, yr.) April 1st, 1915 B. (c) If alive, give age 35 years8. AGE: Years 31 Months 8 Days 18 If less than one day  
..... hrs. .... min.9. Birthplace... Somerset - Maryland  
(Town, county, and state)10. Usual occupation... Housewife and working in crab business

11. Industry or business

12. Name... Hueitt Ballard13. Birthplace... Somerset Co. Maryland14. Maiden name... Annie Turpin15. Birthplace... Somerset Co. Maryland16. Informant... G. W. Tilghman and Gordy YoungAddress... Marion, Maryland17. Burial Date thereof Jan. 21, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Family Graveyard, Marion, Md.

Location .....

18. Funeral director... George W. TilghmanAddress... Marion, Md.19. Jan 21 47 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 17th. 19 47, at 2:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 46 to Jan 17 19 47and that I last saw him alive on Jan 10 19 47Immediate cause of death... Grand DeliriumDue to... Chronic Int. v. v. v.Due to... Chronic v. v. v.

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

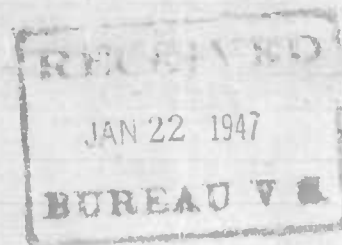
Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE... George W. Tilghman M.D.Address... Marion St. Md. Date signed Jan 18 47



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